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Promoting health and well-being in prisons: an analysis of one year's prison inspection reports

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Abstract

There is renewed optimism about the development of policy and practices related to promoting health in prison settings, driven by the epidemiological data which suggests that the health of people in prison remains very poor. In England and Wales, the focus of this paper, independent prison inspections, conducted by Her Majesty's Inspectorate of Prisons for England and Wales (HMIP), form a critical element in how prisons are assessed. This includes efforts within prisons to promote health and well-being. This paper, using content and thematic analysis, analyses one year (2018) of inspection reports in 38 male prisons. Analysis demonstrates that a 'whole-prison approach' to promoting health and well-being is poorly understood, with only 41% of prisons showing characteristics of this approach. Of the male prisons inspected in 2018, there was good availability of disease prevention activities and screening programmes (88%) and smoking cessation support (94%). The provision of peer support mechanisms, access to condoms and access to health information was highly-variable across prisons. The paper makes several conclusions about the state of health promotion in prison and moreover the current criteria adopted by HMIP to assess health and well-being which seems to offer a very narrow biomedical perspective.

Background

It has recently been stated that prisoner health and well-being is not a luxury; it is a legal entitlement (Health and Social Care Committee House of Commons Education and Skills 2018). However, an analysis of policy aimed to promote health and well-being in prison settings suggests that much more could be done to achieve better health outcomes for people in prison (Woodall 2016). Despite significant reform and momentum in the United Kingdom for promoting health in prison at the start of this millennium (Department of Health 2002, Scottish Prison Service 2002), policy and practice initiatives have since been relatively dormant. There is, however, renewed momentum and emphasis at governmental levels for better and more effective health promotion in prisons (Health and Social Care Committee House of Commons Education and Skills 2018).

Notwithstanding the policy drivers, it is well-stated and recognised that the health of those in prison is poorer than other groups (WHO 2014). This occurs across a plethora of health domains, particularly mental health where epidemiological data show concerning rates of mental illness (Fazel and Danesh 2002, East 2018). Prison health service providers have been exceptional proponents of managing diseases in prison establishments – often described as “*seedbeds of infection*” (Agozino and Volpe 2009, p.4) – as prevention, transmission and treatment is handled effectively. However, a more ‘upstream’ focus on prison health is also widely recognised. Moreover a positive conceptualisation of health, encompassing notions such as improving well-being has long been neglected (Baybutt *et al.* 2018). It is generally agreed internationally (WHO 2014) that the mechanism to enable an upstream approach to happen in prison is a settings approach – or ‘whole prison approach’ – to health promotion which sees the environment, structural issues, physical conditions and policy within a setting as being crucial to achieving optimal health outcomes. Moreover, a core principal of a whole prison approach is the notion of decency in prisons and a recognition that health promotion is ‘everybody’s business’, not just the responsibility of healthcare staff (HMIP 1997). There remains, however, confusion about the definition, conceptualisation and

practice of 'whole prison approaches' (Health and Social Care Committee House of Commons Education and Skills 2018).

To date, efforts to address the health of people in prison have occurred at macro, meso and micro levels but such responses have made little impact in addressing the underlying issues contributing to prison health (Woodall and Dixey 2015). At a macro-level, there has been a global response to addressing prison health which has primarily occurred over the past two decades, led by the World Health Organisation. WHO's strategic oversight has been a salient factor in ensuring that prison health is on the public health agenda of various nations (Gatherer *et al.* 2005). The majority of concerted effort has been undertaken in the European WHO region, with less political appetite for addressing the health of people in prison in other regions, such as North America (Woodall 2018) and Africa (Dixey *et al.* 2015). While the intention of WHO is laudable, there have been critics who argue that the strategic philosophy of addressing prison health and actual implementation 'on the ground' is at considerable odds which has resulted in an uncoordinated global response (Woodall 2016).

At the meso-level, there have been some promising signs of individual countries developing their own approaches to delivering a healthy settings approach in prison – England and Wales (Department of Health 2002) and Scotland (Scottish Prison Service 2002), for example, have led the way by adopting clear strategies for health promotion in prison. In other countries there has been far less activity – in Norway and in Ireland, for instance, there are no dedicated policies for health promotion in prison (MacNamara and Mannix-McNamara 2014, Santora *et al.* 2014) and in several Eastern European regions there is no resource for health promotion in prison (MacDonald *et al.* 2013). In extreme cases, some countries in sub-Saharan Africa are reported to run prisons that are unjust, unhealthy and sites of human rights abuses (Dixey *et al.* 2015). These differences often relate to resource allocation and, in some instances, ideological views on who is deserving or not in regard to health intervention. Those tasked with translating the rhetoric of health promoting prisons into reality have therefore had to navigate a delicate and difficult policy path in which wider public and political opinion is an ever present force (Tabreham 2014). This kind of influence has arguably tempered strategic values from being implemented.

At the micro-level, individual prisons do show commitment to health promotion in prison but according to Caraher *et al.* (2002), many of the lessons learned from health promotion being conducted in prison are being lost due to inconsistent monitoring and evaluation. The reasons for this are complex and multi-faceted, potentially relating to limited resources, staffing reductions and the challenges independent researchers often face in accessing prison sites (Abbott *et al.* 2018). Nevertheless, prisons in several countries are routinely assessed and monitored, through independent inspections, to determine the extent of their safety, decency and, amongst other things, their ability to promote health and well-being.

In England and Wales, the focus of this paper, the current prison population stands at 82,543 (Ministry of Justice 2019). The rate of imprisonment in the UK is 140 per 100,000 of the population and this represents one of the highest imprisonment rates in Northern Europe (Walmsley 2018). This, however, is far lower than other countries such as the United States (655 per 100,000), El Salvador (604) and Turkmenistan (552) (Walmsley 2018). The reasons for the differences in national imprisonment rates have been put forward – Wilkinson and Pickett (2007) have suggested that it is contingent on levels of income inequality, arguing that societies with high income differentials (e.g. USA) are exceptionally punitive, whereas countries that are more egalitarian (e.g. Japan, Norway, Finland) use prison less frequently. Evidence demonstrating that prisoners face disproportionate levels of chronic ill health, disease and disability has been overwhelming and conclusive continually

showing high health and social care needs (WHO 2014). Independent prison inspections, conducted by Her Majesty's Inspectorate of Prisons for England and Wales (HMIP), form one element in how prisons are assessed in relation to assessing the provision of health and well-being initiatives (Bennett 2014). The view provided by HMIP is highly-valuable, given that they have access to all areas of an institution and can arrive unannounced (Hardwick 2016). Prison inspections draw on a range of data, including a confidential survey of a representative proportion of the prisoner population; prisoner focus groups; individual interviews carried out with staff and prisoners; documentation analysis; and observation by inspectors (Bennett 2014). It is a methodology which is recognised for its international excellence (Harding 2006) and having 'influence [that] is so pervasive that the HMIP can be said indirectly to regulate prison conditions' in England and Wales (van Zyl Smit 2010, p.532).

This paper seeks to analyse data from one year (2018) of inspection reports in 38 male prisons in England and Wales. This paper is timely given the increased scrutiny of regulation and inspection in prisons, particularly in relation to health and well-being. A recent report in 2018 by the House of Commons Health and Social Care Committee (2018) outlined a lack of definitional clarity used by HMIP in relation to a 'a whole prison approach' and suggested that recommendations from inspections were infrequently acted upon by the Prison Service. The report signalled a renewed emphasis that HMIP must be listened to and acted on to improve prisoner health outcomes (Health and Social Care Committee House of Commons Education and Skills 2018), thus reasserting the pivotal role of HMIP in shaping policy and practice.

The paper aims to distil the learning and evidence derived from the inspectors. Analysis focuses on the inspectorate's view of 'promoting health and well-being' in male prisons – a dedicated section which can be found in all reports in male prison establishments. Female prisons were excluded, as they are assessed differently in relation to standards for the promotion of health and well-being. Prison inspectors work to a set of "expectations" relating to the level and quality of service that it expects to find in prisons (Reed and Lyne 1997) and in relation to 'promoting health and well-being' in the male estate this includes:

- A whole-prison approach to promoting health and well-being.
- Information about available health services and current national health campaigns that is easily accessible in all required formats and languages.
- Well-trained and supervised peer workers and health trainers who offer health information and support to prisoners.
- Prisoners having easy access to health checks, disease prevention and screening programmes.
- Prisoners having access to sexual health services. Barrier protection and related health advice being freely available, including on release.
- Older patients receiving proactive care from competent staff who understand their specific needs.
- Prisoners able to access community-equivalent smoking cessation support.
- Robust systems to prevent, identify and manage communicable diseases.
- Prisoners receiving individual health promotion advice on release (HMIP 2017).

Methodology

Documentary analysis can take a myriad of forms, but includes the systematic analysis of organisational and institutional reports (Bowen 2009). Prison researchers working toward a greater understanding of health promotion in prison have largely neglected documentary methods, opting instead to pursue empirical approaches (de Viggiani 2007, Woodall *et al.* 2013, Baybutt *et al.* 2018). While these studies have substantially advanced critical debate and dialogue and added rich insight, they often focus on a single, or small number of settings which makes transferability of findings challenging given the heterogeneity of most prisons. This study provides a cross-sectional insight into activities designed to 'promote health and well-being' in prison establishments in England and Wales identified by HMIP. The study used freely available prison inspection reports conducted in England and Wales during 2018. Not all prisons are inspected on an annual basis and therefore our analysis included all 38 reports published in 2018 (the total number of prisons in England and Wales is 118 (Brown 2018)). While this was a desk-based study of data in the public domain, the study protocol was reviewed by XXXXX¹ ethics committee.

Reports were identified through the HMIP website (<https://www.justiceinspectorates.gov.uk/hmiprisons/>), a free to access resource in the public domain. Although independent inspections have been in existence for four decades (Bennett 2014), reports online date back to January 2012. The rationale for sampling reports from 2018 was to provide a contemporary perspective on activities being delivered in prison settings as written reports are published between 8-9 months of inspections taking place. As noted, inspection reports from male establishments were included in the analysis and this included state-run (n=33) and private-run (n=5) establishments. There are fourteen prisons in England and Wales that are managed by private sector companies and the sample here broadly reflects that proportion. While the importance of the health and well-being of women in prison is critical (Gatherer *et al.* 2009), the criterion by which they are assessed by HMIP differs from the male establishment in relation to promoting health and well-being. For this reason, these establishments were excluded from the analysis.

The data in this research was not the totality of each of the reports, rather the unit of analysis was a specific section written by inspectors on 'promoting health and well-being'. This paper is clear that it reporting on the judgements and reporting of inspectors and indeed, it should be noted that some commentators have argued that inspection reports are overly negative and may fail to fully capture good practice in health service delivery (Walsh 2009). All 38 sampled reports were retrieved and the specific section for analysis was identified and then analysed. Data were analysed using two approaches. First, content analysis was undertaken to quantify the activities reported and secondly thematic analysis was used to explore further the data to identify patterns of interest.

Content analysis, an approach well-suited to health research (Kondracki *et al.* 2002), was initially undertaken on the inspection reports. Content analysis has broadly been defined as:

"a research technique for the objective, systematic, and quantitative description of the manifest content of communication." (Berelson 1952, p.55)

Silverman (2015) suggests that content analysis involves the establishment of categories and counting the number of instances these categories or codes are reported in the selected text. While

¹ Anonymised for review

categories or codes can be established both deductively and inductively (Kondracki *et al.* 2002), in this study the former was more appropriately suited given the pre-defined 'expectations' set out in relation to 'promoting health and well-being' by HMIP (Reed and Lyne 1997). These 'expectations' therefore formed the basis of the coding scheme. Our analysis excluded one of the expectations concerning older prisoners – this was because not all prisons in the sample had older prisoners detained in their establishment and it was unclear from the reports which prisons should be offering this support.

Manifest content relates to descriptions which are “on the surface and easily observable” (Potter and Levine-Donnerstein 1999, p.259). A clear coding scheme was therefore designed using an Excel spreadsheet so that analysts could record the manifest content appropriately and accurately (Potter and Levine-Donnerstein 1999). While the *raison d'être* of manifest content analysis is reliability (Kassarjian 1977), some inspection reports offered greater reporting clarity than others. To mitigate this, two coders were involved in the analytical process enabling the systematic process of cross-checking coding and categorisation. A sample of the 38 reports (n=8) were coded independently with discrepancies highlighted, discussed and resolved.

In addition to content analysis, thematic analysis was also undertaken on the 38 report sections. This level of analysis provided richer contextual information and offered a more nuanced perspective on the data set. The analysis was informed by Braun and Clarke's approach to thematic analysis (Braun and Clarke 2006). This involved a level of immersion in the data; identifying and applying codes in the data and, from this, combining and organising these into broader thematic categories.

Findings

This section reports analysis from 38 male prison inspection reports. It is organised under broad categories, mirroring the criteria inspectors use to determine the extent to which establishments are promoting health and well-being. The prisons have not been identified in the reporting.

A strategic, whole-prison approach, to promoting health

In only four reports was there explicit reference to whether prisons did or did not have a whole-prison approach to promoting health and well-being. To this extent, it was difficult to ascertain what criteria or information was providing inspectors with confidence that such an approach was present in the prison. Inspectors instead often reported examples of where policy, strategy and action plans had been developed to promote health across the establishment. Our analysis suggests that 44% of prisons demonstrated a whole-prison approach to promoting health and well-being but the constituent activities comprising this were not clear. In some cases, there was a systematic prison-wide approach to health promotion, supported by dedicated staff, with a myriad of services contributing to prisoners' well-being, most prominently the gymnasium and, in one case, catering staff:

“The prison well-being group, chaired by a member of the catering team, embedded an effective whole-prison approach to health promotion.”

In most cases, however, the co-ordination of a whole-prison approach was lacking:

“Several other prison departments, such as catering, equality and diversity, and the gym promoted health and well-being but there was no systematic, prison wide coordination of these activities.”

Peer support

Access to well-trained and supervised peer workers is regarded by HMIP as a key constituent of efforts to promote health and well-being in prison. However despite this, less than half of prisons (41%) actually had established peer support interventions to support prisoners. In the main, peer workers were not prioritised in the establishments and analysis showed that several peer programmes had been disbanded. In a number of cases, there was no intention to introduce peer workers in the establishment or a cogent rationale for why this was the case:

“There were no health care peer workers available, and no plans to introduce them.”

A number of prisons did view peer workers favourably and clearly recognised the assets that prisoners could bring in supporting the prison’s health and well-being agenda. This not only included working directly at an operational level, but also influencing strategic decision-makers in the individual prison:

“A team of well trained and well supported prisoner health champions...raised prisoners’ awareness of health and well-being and represented their views on health care services at management and governance meetings.”

There was no consistent deployment of peer workers, with individuals in these roles working on a range of health topics and initiatives, including: weight loss and fitness; smoking; educational roles concerning Hepatitis C; and substance misuse. There was no shared model of training, support or delivery observed across any of the inspection reports.

Behaviour modification

Perhaps unsurprisingly, due to initiatives to introduce smoke-free prisons, there was a great deal of emphasis and detail in the inspection reports in relation to smoking cessation support and the execution of smoke free policies in the prison. Our analysis identified that 94% of prisons had smoking cessation support which was equivalent to that found in the community. In exemplar prisons, there was a range of interventions to support prisoners in their attempts to stop smoking, including pharmacological, professional and peer support:

“The prison had been smoke-free for two months and prisoners had good access to nicotine replacement therapy, along with peer and professional support.”

Some prisons had thought carefully about their smoking cessation support and, in some cases, in order to maintain safety and decency in the prison, had curtailed pharmacological support. This potentially raises questions about the extent to which prisoners could maintain smoking cessation over an extended period of time:

“Only six weeks of nicotine replacement treatment was now provided following significant bullying and violence related to its use in 2017. There was no psychosocial support to help prisoners with smoking cessation.”

In some of the inspection reports, smoking cessation support was not provided universally causing variance within institutions. There were few cases where a clear rationale for these decisions were made, although one prison made judgements based on sentencing decisions:

“Smoking cessation support was available. However, only boys who were sentenced were offered nicotine replacement patches and not on the first night. This did not meet the needs of all boys.”

These decisions on availability of services was causing confusion, adverse effects and, broadly speaking, inequalities in some of the prisons:

“Smoking cessation support was provided by both the health services team and prison officers, depending on location. Provision was too variable and we noted confusion from prisoners and officers about availability and eligibility. This resulted in a perceived disparity of access to nicotine replacement therapy among prisoners, and fuelled illicit tobacco use.”

Condoms were reported to be available in 88% of prisons, although the reports consistently showed reluctance for prisons to advertise these and access was rarely straightforward. Accessing condoms frequently seemed to be a convoluted process. This was a repetitive theme throughout the inspection documents, illustrated below:

“Sexual health services were provided and condoms were available, although not advertised.”

While only half of prison were reported to provide sexual health advice to prisons, there was seemingly good practice in this regard with specialist staff coming into some prisons to deliver this service and some specialist advice in certain institutions.

Disease prevention and screening

The majority of prisons inspected in 2018 were exceptionally proficient at managing and screening for diseases in prison. Analysis suggested that 88% of prisons enabled easy access to health checks, disease prevention and screening programmes. There were few instances where support and healthcare provision were deficient in this domain. Activities were age-specific and appropriate and appropriately targeted. In one prison, inspectors noted:

“Prisoners could access a full range of health checks, immunisations and screening programmes to facilitate disease prevention.”

Where mentioned in the reports, prisons were highly-effective at managing outbreaks and had established clear protocols to minimise any health impacts caused by, for example, communicable diseases; and diarrhoea and vomiting.

Health information

Two-thirds of the sampled prisons inspected in 2018 were providing ‘easily accessible’ information about health services and ‘easily accessible’ information about current national health campaigns. This mostly comprised leaflets or newsletters advertising and promoting relevant topics and agendas:

“A wide range of eye-catching health promotion material was displayed in the health care centre and throughout the prison.”

In a few cases, specialist personnel were designated to oversee this within the institution:

“A full-time health promotion practitioner ensured a wide range of health information leaflets, linked to national campaigns, was available.”

The focal point of the provision of health information was undertaken in the prison health facilities, with few examples or suggestions that this happened in other areas of the establishment. In some prisons, inspectors noted that information was not provided anywhere in the establishment:

“National health campaigns did not guide health promotion services, and there was limited health promotion information displayed on residential wings. The health centre did not provide health promotion leaflets, and the induction process did not include health promotion information.”

The inspectors assessed the extent to which health information was offered in other languages and formats. While only 19% of prisons were reported to do this, there were some exemplary practices noted:

“The new health care centre provided an impressive, dedicated health promotion space, and a wealth of literature was freely available in a range of languages.”

“A wealth of information, based on national health campaigns, was available throughout the prison. Telephone interpretation services and translated health literature were also available.”

In one prison, materials could be translated but this was not advertised or promoted widely.

Continuity of care

Prisons were further expected to ensure that continuity of care was extended to promoting health and well-being when people in prison were released. The data suggested that very few prisons were involved in activities associated with supporting prisoners' health and well-being prior to their release. Indeed, only 19% of prisons offered individual health promotion advice on release. Where advice was provided, it focused on harm minimisation and/or providing condoms, rather than on other aspects of well-being:

“Barrier protection and harm minimisation advice was available from health staff and offered on release.”

Discussion

This paper sought to ascertain and understand the activities relating to promoting health and well-being reported by HMIP. The paper reported analysis of 38 prison inspection reports in male establishments published during 2018. The importance of the inspection report has been long-standing and recognised, but there has recently been a re-emphasis on the power that inspection reports have in shaping policy and practice in prison health (Health and Social Care Committee House of Commons Education and Skills 2018). This research is therefore timely in understanding the inspectorate's specific view of health and well-being in prison establishments.

Our data reinforced the perception that the provision of health and well-being in prisons is varied, but with pockets of good practice. What was clear, however, was there was no consensus on what a 'whole-prison' approach to promoting health and well-being was. Our data emphasised the view that the concept of a 'whole-prison' approach is becoming highly-confused and lacking definitional consensus. A point now being made at high political levels (Health and Social Care Committee House of Commons Education and Skills 2018). However, one attribute which seemed important to a whole-prison approach was cross-departmental collaboration within the prison – this was only seen, however, in a minority of prisons in the sample. A previous analysis of health promotion activity in prison showed that physical education staff were involved in health promotion in 31% of prisons (Caraher *et al.* 2002). Yet, our data shows that prisons still tend to lack a fully integrated approach, with different departments operating in isolation from one another (Meek 2018). Others have noted how there remains underused opportunities for a range of staff to work in partnership to

promote health (Meek 2018). The domination of healthcare staff was apparent, indeed within health promotion performance targets it is suggested that members of any health promotion action group are drawn from a range of prison departments, including: healthcare, catering, physical education, general education, substance misuse services, chaplaincy and mental health services (NOMS *et al.* 2007). This was not seen in the majority of the sampled prisons.

Peer support processes continue to be a popular intervention within the prison setting and recent evidence derived from a systematic review has demonstrated the value of this in relation to a spectrum of health and social issues (Bagnall *et al.* 2015). Our analysis suggested that only 41% of prisoners were utilising peer support approaches for health and well-being. The inspectors view, however, seems to disregard the Listener scheme (Dhaliwal and Harrower 2009) as it was not mentioned at any point under the promoting health section of the inspection reports – this seems confusing given the pivotal role Listeners play in many prisons in England and Wales. The last comprehensive analysis of health promotion activity in prison showed that almost three-quarters of prisons had some form of peer education or support, but it is highly likely that this included the Listener scheme (Caraher *et al.* 2002). Trained prison peers offer expertise “by experience” (Durcan and Cees Zwemstra 2014, p.93) with studies demonstrating that prisoners were more likely to confide in peer-deliverers, rather than staff, because they were less likely to be judged for the things they said (Foster 2011). Given broader evidence, that peer support in prison offers a myriad of benefits it is surprising that this approach was not more common (indeed, some prisons were actively ceasing this mode of intervention). Moreover, within the inspection reports there was no standardisation across the peer schemes and there was considerable heterogeneity in the range of peer-based interventions in the prison setting (South *et al.* 2014).

The analysis suggested that prisons performed exceptionally well at disease prevention and in ensuring that any outbreaks were managed appropriately. It could be argued that these interventions are perhaps aimed at the effective management of the prison population, rather than for promoting health benefits *per se*. Whether the same resource is provided to prevention activities, as opposed to promotion, is debateable given the data and comments from the inspection reports. The implementation of the smoke free policy in prisons across England and Wales was predicted to see prisons go through a major period of change and reform (O’Moore *et al.* 2014). While the smoke-free prison agenda dominated the 2018 reports, most prisons were managing this successfully. A limitation of this study is that the contextual and process challenges in implementation were not discussed in detail, with other studies highlighting significant challenges faced in implementing the smoke-free prison agenda (Woodall and Tattersfield 2017). One clear issue noted in regard to smoking cessation, however, were inconsistencies in smoking cessation support and inequalities in how this was provided.

This research has uncovered a broader point, in that the current criteria adopted by HMIP seems to offer a very narrow perspective on health and well-being – issues concerning mental health, for instance, is not considered within HMIP’s criteria for promoting health and well-being (there are specific criteria for mental health in prison, but these are fragmented away from promoting health and well-being). Moreover, there does not seem to have been wide discussions with a range of stakeholders on the most suitable criterion for assessing health and well-being. Indeed, we would argue that the criteria utilised reinforces health promotion as something that is reactionary and individualistic, addressing specific disease prevention targets that respond to the physical, psychological, emotional and social needs of individuals in only a partial way (de Viggiani 2006a, de Viggiani 2006b). Baybutt *et al.* (2010) have optimistically argued that the medical model of health provision in prison has been reformed; however, the discourse surrounding health in prison,

particularly efforts to promote health, keeps its heavy, unbalanced focus on disease control, eradication, screening and testing. If health promotion is to be developed further in prison, then the prevention of disease and the promotion of positive health need to be more carefully balanced (Caraher *et al.* 2002). Whilst it is accepted that preventive measures are included within many conceptual frameworks of health promotion (Downie *et al.* 1996), more radical perspectives would see health promotion focussing primarily on advancing individuals towards the positive end of the disease-health continuum (Brubaker 1983, King 1994, Breslow 1999). There is also concern in regard to the focus on lifestyle issues at the cost of a more social determinants approach. Others have discussed the challenge of 'lifestyle drift' in prisons (Woodall 2016) with various factors reported in regard to why this may be a preferred approach – the ease of delivery and evaluation being a prime example (Carey *et al.* 2016). Given our analysis, we would strongly advocate for a broader conceptualisation of prison health and well-being and we have outlined how this may be done elsewhere (Woodall *et al.* 2014). Other authors have advocated a similar position (Marshall *et al.* 2000) and this would include retaining some of the current criteria, including peer intervention and interventions that are strategic and comprehensive, rather than opportunistic.

One of the limitations of the study is that the inspection reports were not produced for research purposes and therefore lack details and specificity. This is a common challenge in documentary analysis (Bowen 2009). Moreover, in the context of this study, they are premised on the inspectors reporting fully on the situation in the establishments. Given the brevity of some reports, there is a possibility that a broader spectrum of activity is being conducted under the 'promoting health and well-being' agenda. Nonetheless, if this is the case, why is this not being reported fully? The paper, as discussed earlier, focused on the male prison establishment and future research must take a wider examination of the situation in the female prison estate.

Conclusion

This paper ascertained a cross-sectional view of promoting health in prison. Notwithstanding the limitations mentioned, it seems clear that while approaches to health, particularly health promotion, have developed considerably within prisons there is still a significant way to go. Promoting health in prison seemed to be implemented on sporadic, ad-hoc occasions with little coherent planning. Arguably, health promotion should instead be continuously present in the organisation's ethos (Graham 2007), as this would avoid Dooris' (2001, p.58) notion of "*project-ism*" in settings. If senior leaders wish for prisons to be healthier settings which have a significant opportunity to impact on health inequalities, then clear criterion for promoting health should be developed that examines the causes of the symptoms of poor health, not just the symptoms. HMIP is in an ideal position to influence and advocate this perspective but seemingly reinforce a narrow and disease-focused position.

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